

Aggiornamenti dalla VII Joint Breast Cancer Conference e nuove linee guida del gruppo europeo dei patologi

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Wednesday 24 March	Thursday 25 March	Friday 26 March	Saturday 27 March
07:30 - 19:00 Registration			
08:30 - 13:00 Society Workshops	08:30 - 09:15 Teaching Lectures Europa Donna Teaching Lectures	08:30 - 09:30 Teaching Lectures Europa Donna Teaching Lecture	
		08:30 - 10:30 Metastatic Breast Cancer Guidelines Workshop	
	09:30 - 10:30 Patient Management Workshops Challenge the Experts	09:30 - 10:30 Debates	
	10:30 - 16:30 Exhibition		
	11:00 - 12:30 Keynote Symposium	11:00 - 13:00 Keynote Symposium	
12:00 - 13:30 Lunch and Poster Viewing	12:30 - 14:00 Lunch and Poster Viewing		
12:00 - 19:15 Exhibition		13:00 - 13:10 Closing Remarks	
13:30 - 14:30 Opening Ceremony	14:00 - 15:00 Debates	13:30 - 15:00 Satellite Symposia	
15:00 - 17:00 Keynote Symposium	15:30 - 17:00 Clinical Science Symposia Europa Donna Sessions		
17:15 - 18:00 Poster Discussion Sessions Europa Donna Wrap-up Session			
18:00 - 19:15 Poster Viewing including drinks and tapas			
19:15 - 20:45 Satellite Symposia			
	19:30 - 21:30 TRANSBIG workshop		

Teaching Lectures are a combination of a didactic state-of-the-art lecture by a recognised expert in the field and interactive discussion with the audience.

The format of the Oxford union style debate allows for two persons proposing a resolution and two persons opposing it. Each individual will be flanked by a 'seconder'.

The Patient Management Workshop is an interactive session coordinated by 2 coordinators presenting one clinical case linked to the Teaching Lecture topic. Management options will be discussed for this topic and there will be interaction and discussion with the audience.

Interactive session where the moderator will present a case based presentation, followed by an open discussion between the audience and experts.

These are sessions focusing on the latest perspectives of basic research and clinical treatment in breast cancer. A keynote speaker is

Clinical Science Symposia will include invited speaker presentations as well as selected oral presentations (to be selected in January 2010).

A short summary of each Clinical Science Symposium will be presented.



European Group for Breast Cancer
Screening Programme

Current Issues in Breast Cancer Screening 09:00 - 12:00

Session One – Results Update

Chairs: R. Wilson (United Kingdom)

M. Roselli del Turco (Italy)

- **Evidence for screening older women?**
Speaker: H. de Koning (The Netherlands)
- **Is there evidence that breast screening has saved lives?**
Speaker: P. Autier (France)
- **Discussion panel**
H. De Koning, P. Autier, F. Gilbert, A. Ponti

Session Two – Technology Update

Chair: F. Gilbert (United Kingdom)

A. Ponti (Italy)

- **What new evidence on digital mammography and screening?**
Speaker: P. Skaane (Norway)
- **Making digital mammography work for screening**
Speaker: C. de Wolf (Switzerland)
- **Overview on current data on digital tomosynthesis imaging**
Speaker: F. Thibault (France)
- **Critical appraisal of computer aided detection (CAD)**
Speaker: P. Taylor (United Kingdom)
- **Discussion panel**
P. Taylor, F. Thibault, C. de Wolf, P. Skaane



International Breast
Ultrasound School (IBUS)
Special Workshop

Breast Ultrasound – Update

09:00 - 13:00

- **Role of assessment ultrasound in DCIS and small cancers – Experiences of mammography screening programmes**
Speaker: W. Heindel (Germany)

Europa Donna Session

15:30 - 17:00

Implementation of the European Union Guidelines for quality assurance in breast cancer screening and diagnosis

Chair: I. Kössler (Sweden)

- **Mammography screening – what is going on in Europe**
Speaker: A. Scharpantgen (Luxembourg)

Debates

14:00 - 15:00

This house believes that the future of breast cancer prevention is through pharmacological interventions

Moderator: B. Borisch (Switzerland)

Speaker in favour: J. Cuzick (United Kingdom)

Seconder: A. Decensi (Italy)

Speaker against: I.F. Tannock (Canada)

Seconder: D. Cameron (United Kingdom)

This house believes that it is better to screen patients for Tamoxifen metabolism rather than give everyone aromatase inhibitors

Moderator: W. Jonat (Germany)

Speaker in favour: C. Coombes (United Kingdom)

Seconder: To be announced

Speaker against: C. Rose (Sweden)

Seconder: H. Jernström (Sweden)

Europa Donna Session

15:30 - 17:00

Implementation of the European Union Guidelines for quality assurance in breast cancer screening and diagnosis

Chair: I. Kössler (Sweden)

- **Breast specialist perspective**

Speaker: M. Rosselli del Turco (Italy)

- **Mammography screening – what is going on in Europe**

Speaker: A. Scharpantgen (Luxembourg)

- **Advocacy perspective**

Speaker: S. Knox (Italy)

Teaching Lectures

08:30 - 09:15

Implementation of breast cancer screening

Chair: J. Cuzick (United Kingdom)

Speaker: S. Heywang-Köbrunner (Germany)



European Society of
Surgical Oncology Workshop

The Future of Sentinel Lymph Node Biopsy

09:00 - 13:00

Introduction

Coordinator: L. Cataliotti (Italy)

Session One – Sentinel Lymph Node Biopsy Today: State of the Art

Chair: H.S.A. Oldenburg (The Netherlands)

Speaker: E.J.T. Rutgers (The Netherlands)

Speaker: R. Valdes-Olmos (The Netherlands)

Session Two – Pathological Issues – Round Table

Panel: S. Bianchi (Italy), G. Viale (Italy),
G. Cserni (Hungary), P. Van Diest
(The Netherlands)

- **Definitions (OTC versus micro metastases)**
- **Frozen section: yes or no?**
- **Pathological examination of sentinel lymph node**

Session Three – New Indications to Sentinel Node Biopsy

Chair: P. Veronesi (Italy)

- **SNB after breast surgery and in multicentric disease**
Speaker: O. Gentilini (Italy)
- **SNB during pregnancy and SNB in male breast cancer**
Speaker: V. Galimberti (Italy)
- **SNB in DCIS**
Speaker: P. Veronesi (Italy)

Session Four – Sentinel Node Biopsy in Neo-Adjuvant Chemotherapy

Chair: C.J.H. van de Velde (The Netherlands)

- **Why before and not after?**
Speaker: C.J.H. van de Velde
(The Netherlands)
- **What a medical oncologist thinks about sentinel node biopsy before, after and before and after (if possible) neo adjuvant chemotherapy**
Speaker: J.Y. Pierga (France)

Session Five – New Methods

Chair: L. Cataliotti (Italy)

- **Image guided surgery on sentinel node**
Speaker: A.L. Vahrmeijer (The Netherlands)
- **Expert using nucleic acid amplification for intra operative detection of LN**
Speaker: F. Di Filippo (Italy)
- **Expert using gene search breast lymph node assay**
Speaker: G. Viale (Italy)

nuove linee guida del gruppo europeo dei patologi

Approvazione definitiva Zurigo 12-13 giugno 2010

Atypical ductal hyperplasia (ADH) European Group

The diagnostic criteria used to define ADH are imperfect.

At present it is recommended that the diagnosis of ADH should be restricted to lesions which show the features described by Page et al (the cellular changes of DCIS are present but occupy less than 2 separate duct spaces is widely accepted) to which the quantified risk of developing breast carcinoma is linked.

Even then the diagnosis of ADH should be made with caution and only if low grade DCIS has been seriously considered in the differential diagnosis.

Lesser changes for which the possible classification lies between florid UEH and ADH are less relevant with regard to a risk of developing breast carcinoma and should not be classified as ADH.

However it should also always be borne in mind that a proliferation at the edge of a biopsy may represent the periphery of a more established lesion of DCIS and further excision of the adjacent tissue may be warranted.

Columnar Cell Lesions in Breast Core Biopsies

CCLs with atypia should be regarded as FEA and classified as B3, of uncertain malignant potential.

Lesions with more complex architecture should also be regarded as an atypical epithelial proliferation and also regarded as B3, of uncertain malignant potential

As for all such screen-detected lesions, multidisciplinary discussion should be undertaken to correlate radiological, clinical and histopathological findings. Data on risk of finding adjacent, associated malignancy are extremely limited

MICROINVASIVE CARCINOMA

Microinvasive carcinoma is defined as a tumour in which the dominant lesion is in-situ carcinoma (usually extensive high nuclear grade DCIS, but rarely other types of DCIS or LCIS) in which there are one or more, clearly separate, foci of infiltration usually into nonspecialized interlobular³ or interductal fibrous or adipose tissue, none measuring more than 1 mm (about 2 high power fields) in maximum diameter.

When there are multiple foci of MIC only the size of the largest focus is used to classify the microinvasion; the presence of multiple foci of microinvasion should however be noted and/or quantified.

A focus of invasive carcinoma 1 mm or less without associated *in situ* carcinoma is not MIC but should be classified as invasive carcinoma and the maximum diameter measured.

Frozen Sections

Tumours less than 1cm in size or impalpable lesions should not be subjected to frozen section diagnosis. Frozen section examination of needle core biopsies is universally inappropriate.

Margin assessment

No consensus exists regarding the method of intraoperative margin assessment.

Frozen sections of margins for breast cancer may be regarded unnecessary in cases where specimen radiology is performed and reported to an adequate standard.

Sentinel lymph node biopsy

Frozen sections for intraoperative assessment of sentinel lymph nodes (as frozen sections in general) should only be performed in cases with impact on immediate surgical treatment.

The risk of false negative results is reported to be between 9 and 52% (6). Rarely false positivity may occur. Overall the accuracy is reported to be between 79 and 98%. In addition, during frozen sectioning, tissue loss may occur which must be kept minimal. Imprint cytology is an acceptable alternative in centres with cytological expertise.

Lymph node cytology /core biopsy assessment

Preoperative staging of axillary lymph nodes (ALN) should be performed, in order to adopt specific therapeutic decisions.

Diagnosis is usually straight forward when representative material is available with good technical quality; most false negative cases correspond to “small” metastases.

All cases with negative results are candidates for SNB or other axillary procedure for definitive staging.

Sentinel Lymph node biopsy

The guidelines state that the **minimum aim of SLN investigation is to find all metastases greater than 2 mm** (further referred to as macrometastasis).

One of the aims of the guidelines is to decrease heterogeneity in staging. This should **concentrate on the reliability and accuracy of determining the node-negative status**.

No reasonable histological method can aim to identify ITCs with 100% accuracy in a SLN, but some reports have suggested that ITCs identified incidentally with protocols devised to identify larger metastases have also some impact of on prognosis

Sentinel Lymph node biopsy

The seventh edition of the TNM has introduced an **alternative upper limit of 200 cells for ITCs** [2, 10], and **this should reduce the diagnostic discrepancies** between different centres and should also reduce the unacceptable practice to label rather large metastatic involvement of a lymph node as pN0(i+). Although this limit of fewer than 200 cells is suggested **for a single histological cross section [10], the current guidelines would extend this limit to a three dimensional interpretation, including consecutive step sectioned levels of the SLNs.**

It must be noted that **a validated quantitative RT-PCR based assay** (and validation studies have already been published) **will disclose nodal involvement greater than ITC**, and therefore the **pN0(mol+)** recommended by both the 6th and 7th edition of the TNM is obviously **inadequate** to describe this nodal status, which should be reported as **node positive (pN1) with ... (named) molecular assay**, as the **pN1(mol+)** category that would be adequate to report such a finding is not part of the TNM

Sentinel Lymph node biopsy

As concerns sampling of the SLNs, a compromise should be made between the use of practically the whole lymph node tissue for the molecular assay (aiming at the highest accuracy in staging) and the use of a part of the SLN for histology and the allowing only the rest for the molecular assay (aiming at increasing the accuracy of staging, but also allowing a more complex histological evaluation of the lymph node).

Many pathologists would agree that **no molecular assay should be carried out with the whole of the nodal tissue**, as the molecular staging assay is simply a test for the presence or absence of metastases, whereas histology is a more complex diagnostic method capable of identifying other nodal disorders too. However, should the first approach be favoured, **it is recommended that at least a frozen section or a (touch or scrape) cytology specimen is taken for a microscopic control of the SLN tissue**

In the non-intraoperative setting histology is the method of choice for SLN assessment.

Towards Molecular Classification Of Breast Cancer

Pathological Reporting Of Post-chemotherapy Specimens

Vacuum-assisted Needle Core Biopsy (Vancb)

Multidisciplinary Discussion